	DEPARTMENT OF PUBLIC SAFETY CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: 05/12/2003	POLICY NO.: COR.10.1E.06
		SUPERSEDES (Policy No. & Date): COR.10D.15 01/09/98	
	SUBJECT: ORAL CARE		Page 1 of 5

No. 2003-468

1.0 PURPOSE

To provide oral care to inmates under the direction and supervision of a dentist licensed in the State.

2.0 REFERENCES AND DEFINITIONS

.1 References

- a. HRS, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care Standards for Prisons and Jails, (2003), Oral Care.
- c. American Dental Association.
- d. American Correctional Association Standards for Adult Local Detention Facilities, (1991), dental Screening and Examination.
- e. Department of Public Safety Policy and Procedures Manual, COR.10A.16, Inmates Requesting Private Medical Care Provider.
COR.10.1G.11, Prostheses
COR.10.1H.05, The Transfer of Medical Records.

.2 Definitions

- a. Universal Dental Recording System: A mean of identifying teeth by number.
- b. Prosthetics: Artificial devices to replace missing body parts; in this case, dentures, bridges, etc.

3.0 POLICY

- .1 Dental examinations and treatments for inmates shall be performed by, and under the direction and supervision of, a dentist licensed to practice in the State of Hawaii.

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- .2 Dental care of inmates shall be timely and includes immediate access for urgent or painful conditions. The inmate's serious urgent and emergent dental needs shall be met.

4.0 **PROCEDURES**

- .1 Dental screening of newly admitted inmates shall occur within fourteen (14) days of admission into the Department of Public Safety (PSD) jail facilities and seven (7) days after admission to prison facilities. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new screening at the receiving facility if the documentation in the dental record is received within the 14 to 7 days respectively.
- .2 The dental screening shall include visual observation of the teeth and gums, noting any gross abnormalities which require immediate referral to a dentist. Health staff with documented training by a dentist can perform dental screens. The screening shall be recorded in the dental record.
- .3 Instructions in oral hygiene and preventive oral education are given within one (1) month of admission by a dentist, dental hygienist, or health staff with documented training by a dentist.
- .4 A dentist shall perform a dental examination on all inmates within thirty (30) days of admission to a PSD prison facility and within one (1) year of admission to a PSD jail facility. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new examination at the receiving facility if the documentation in the dental record transfers with the inmate.

Inmates who are re-admitted and who received a dental examination and treatments within the past year do not require a new examination unless so determined by the supervising dentist.

- .5 Dental examinations shall include taking the patient's dental history, and extraoral head and neck examination, charting of teeth and examination of hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. The examination results shall be recorded on Form DOC 0424 Dental Examination (Attachment A) utilizing a number system, such as the Universal Dental Recording System (e.g., 1-32, A -T).

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- .6 Oral treatment shall be prioritized for emergencies, acute injuries to the teeth, acute injuries to the oro-facial complex, infection control, pain management, proper mastication and maintaining the patients' health status.
- .7 Bitewing x-rays and additional radiographs may be taken at the time of the patient's first treatment appointment and thereafter as indicated.
- .8 Each inmate shall have access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.
- .9 Extractions shall be performed in a manner consistent with community standards of care and adhering to the American dental association's clinical guidelines. Extractions are limited to the following:
 1. Non-restorable teeth;
 2. Periodontally compromised teeth; and
 3. Severe, acute or chronic infection.

Informed patient consent for extractions is required on DOC 0427, Consent to Operation, Post Operative Care, medical Treatment, Anesthesia or Other Procedure (Attachment B).
- .10 Inmates can seek private dental care at their own expense under COR.10A.16, Inmates Requesting Private Medical Care Provider. For security reasons, dental staff should encourage the private provider to come to the facility to provide the services. Approval for private provider care must be approved by the Correctional Health Care Administrator or designee.
- .11 Medical reviews of any inmates to be transferred to another correctional facility shall include consideration of any pending dental work. Should an inmate's pending transfer involve a facility at which an institutional dentist is not readily available and the inmate has major uncompleted dental work pending, the inmate shall not be transferred until dental services have been completed.
- .12 All dental records shall be confidential. These records shall be maintained for all patients and shall include as indicated the:

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- a. Dental Treatment Record, DOC 0409 (Attachment C).
 - b. Dental Health Questionnaire, DOC 0411 (Attachment D).
 - c. Refusal to consent to Medical/Surgical Treatment/Medication, DOC 0417 (Attachment E).
 - d. Dental Examinations.
 - e. Consent to Operation, Post Operative..., DOC 0427, (Attachment B).
 - f. Perio Chart.
 - g. Dental Problem Sheet, DOC 0475 (Attachment F).
 - h. Medical Needs Memo, DOC 0449 (Attachment G).
 - i. Consultation Record, doc 0406 (Attachment H).
 - j. X-rays.
- .13 When an inmate transfers to another PSD facility, the dental record shall be packed with the medical record and transferred according to P & P COR.10E.03, The Transfer of Medical Records.
 - .14 Dental records shall be notated in S-O-A-P or problem oriented format. All notes shall include the client's complaint, the examination, the diagnostic impression, and the treatment and treatment plans.
 - .15 Form DOC 0406 Consultation Record shall accompany the inmate to an outside dental referral. DOC 0406 will also be used when a dental consultant comes to the facility. The Consultation Record and the consultant's report shall be filed in the Consultation Index of the medical record. A copy of the consultation Record and consultant's report shall be filed in the dental record.
 - .16 All dental staff shall practice universal infection controls and infection controls. Infection control practices are defined by the American Dental Association and the Centers for Disease control and Prevention as including sterilizing

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instruments, disinfecting equipment, and properly disposing of hazardous waste.

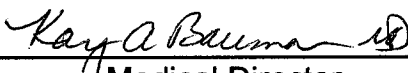
No inmate shall be denied dental treatment because of an infectious condition.

- .17 Reviews of dental services will be included in the PSD health services quality assurance program as described in P & P COR.10A.05, Quality Improvement Program.

5.0 SCOPE

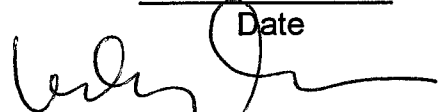
This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:



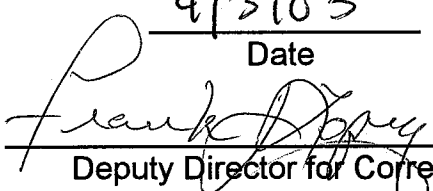
Medical Director
5/21/03

Date



Correctional Health Care Administrator

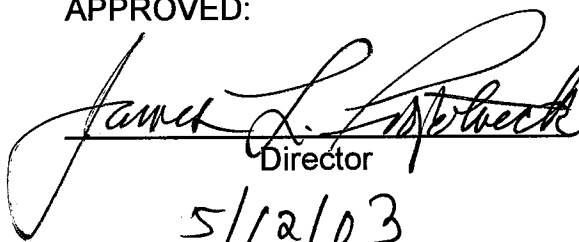
4/3/03

Date


Deputy Director for Corrections
5.10.03

Date

APPROVED:



Director
5/12/03

Date

CATEGORY CLASSIFICATION:



FACILITY _____

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
DENTAL EXAMINATION

NAME _____ D.O.B. _____ SSN _____

Date Admitted _____ Exam Date _____

Medical Alert _____

A diagram of a human dental arch, likely a maxillary (upper) arch, showing 32 teeth. The teeth are arranged in a single row and are labeled with numbers 1 through 32. The labels are positioned below the teeth, with 'RIGHT' on the left side and 'LEFT' on the right side. The teeth are numbered 1 to 16 from right to left, and 17 to 32 from left to right. The diagram shows the general shape and arrangement of the teeth, including incisors, canines, premolars, and molars.

Classifications:

Plaque _____

Stain _____

Calculus deposits _____

Slight____ Mod____ Severe____

Gingiva _____

Recession _____

Periodontal Condition _____

Prosthetics: FUD FLD PUD PLD

B. EXTRAORAL INSPECTION	Normal	Abnormal	COMMENTS:
Face			
Head			
Neck			
Lymph Nodes			
TMJ			
C. ORAL INSPECTION			
Lips			
Vestibule			
Mucosa			
Pharynx			
Tonsils			
Gingiva			
Palate			
Tongue			
Floor of the Mouth			

**CONSENT TO OPERATION, POST OPERATIVE CARE,
MEDICAL TREATMENT, ANESTHESIA, OR OTHER
PROCEDURE**

Patient: _____
SSN: _____ DOB: _____
Facility: _____ Date: _____

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision.

(1) Explain the nature of the condition(s) in professional and ordinary language. Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.

PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

- a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
- b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
- c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
- d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
- e) ANTICIPATED RESULTS OF THE TREATMENT.

Patient/Other Legally Responsible Person Sign, If Applicable

Date

Physician

Date

NAME: _____

[illegible]

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: _____ SSN: _____ SID: _____

DOB: _____ FACILITY: _____ DATE: _____ TIME: _____

I, the undersigned patient, refuse the following treatment and/or medication: _____

(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility, the Health Care Division, and its medical personnel from any responsibility whatever for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

(Print Name of Patient)

(Signature of Patient)*

(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health.

(Print Name)

(Signature & Title)

(Date)

A referral has been made to the attending physician: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

(Print Name of Provider)

(Signature & Title)

(Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

(Print Name & Title)

(Signature & Title)

(Date)

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

DENTAL PROBLEM SHEET

Name: _____

Facility: _____

	Problem	Date Observed	Date Completed	NOTES
1.				
2.				
3.				
4.				
5.				
6.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

MEDICAL NEEDS MEMO

Facility: _____

Date: _____

TO: _____

FROM: _____

(Signature/Title of Provider)

Inmate _____
(Print Inmate's Name)

Housed in _____

DURATION: _____ Days; _____ Weeks; _____ Months; _____ Indefinitely

Duration not to exceed three months for medication reviews for chronic illnesses.*Health Status Classification Report required if there is a significant change in health status.*

Original: UTM/ACO/Work Supervisor

Canary: Medical Record

Pink: Inmate

DOC 0449 (12/2002)

CONFIDENTIAL

CONSULTATION RECORD

Facility

S.I.D.

Name	Last	First	Initial	DOB	SSN
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REQUEST TO:	DATE OF APPOINTMENT:	TIME:
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REASON FOR CONSULTATION:

Date

Requesting Physician M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

M.D.

Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

Original: HCU

Yellow: Consultant's Copy

DOC 0406 (11/97)

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